HEALTH SECTOR DEVELOPMENT IN THE PHILIPPINES
Supplemental Development Activity Approval Document (DAAD)

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I. Purpose of the Supplemental DAAD

USAID's assistance program to the health sector in the Philippines covers family planning, maternal and child health, TB, HIV-AIDS and addresses issues in both the public and private sectors. The Mission's country strategy was updated in 2005 and covers the period FY2005-2009. As the strategy rolls out, the various projects within the health program are being reviewed and amended or replaced in line with the strategy.

Originally called Health Enhancing Local Partnerships-Local Government Units (HELP-LGU) Project, and later changed to Local Enhancement and Development for Health (LEAD for Health) Project, this activity was authorized on March 27, 2003. This supplemental DAAD sets forth the following:

(1) Change of activity title to Health Sector Development Project (HSDP) and reflect the cross-cutting health governance concerns and policy issues that the Project will focus on.
(2) Expand the scope of current infectious disease activities to cover not only TB but other emerging and re-emerging diseases such as avian influenza (AI), severe acute respiratory syndrome (SARS), and malaria.
(3) Extend Project completion from FY 2009 to FY 2011.

II. Problem Statement

Improvements in the country's health situation continue to be precarious. While no major epidemics have occurred in the last five years, the main threats to Filipinos' health remain to be high levels of population growth, tuberculosis, declining nutritional status of women and children, potential rapid increase in HIV-AIDS as high-risk behaviors such as injecting drug use are now being acknowledged, re-emerging diseases such as malaria, and the threat of emerging diseases such as SARS and AI.

Improved control of infectious diseases is increasingly important for the Philippines in light of new, emerging threats to public health, including those of Avian influenza, severe acute respiratory syndrome (SARS), TB and malaria. Despite the availability of an effective treatment regimen, the Philippines has the eighth highest prevalence rate of TB in the world. SARS continues to be a threat to the health of populations while malaria continues to plague those in rural areas, in part because of the increasing resistance to anti-malarial drugs.

The Philippines has maintained its avian flu-free status to date. However, there is growing concern about it moving to be a high risk country considering the degree of epidemic in the region. The country is directly situated in the migratory bird flyways and therefore, is vulnerable to avian influenza being transmitted from affected countries and regions where the virus has been located. With the novelty of the infection, inadequate knowledge about the infection and its causative agent, the high fatality and the absence of effective vaccine for avian flu, there is urgent need to review surveillance activities and advice on areas requiring USAID support to enable effective systems particularly in the AI sentinel sites.

For these infectious diseases where the threat of developing into epidemic proportions rapidly is big, the challenge lies in working through a decentralized system and where local authorities play a crucial role in the containment of any infectious disease in case it develops into a national crisis. It is important that systems and procedures are available to knit local action and national policy/technical guidance into a responsive machinery.

Current activities such as the LEAD for Health and EnRICH Projects seem to have gained headway in the past three years. LEAD for Health has enrolled more than 500 LGUs that are now receiving technical assistance. It has contributed to the initial clarification and enunciation of the Philippines' contraceptive self-reliance policy in partnership with the Department of Health (DOH), Philippine Health Insurance Corporation (PhilHealth) and Commission on Population (POPCOM). LEAD for Health, in partnership with the League of Municipalities (LMP), supported in the implementation of responsible parenthood and reproductive health activities. A number of LGUs are now promoting the program and allocating funds to purchase contraceptive supplies and strengthen service delivery.

The ongoing EnRICH Project in the ARMM has resulted in organized communities being more responsible and involved in improving their health status. Various training on family planning, TB and maternal and child health have been conducted to improve the skills of local health providers. Two provincial "fatwas," religious edicts supporting family planning and reproductive health, have been declared by Muslim religious leaders and are currently being disseminated to the Muslim population. A Floating Clinic has been rehabilitated in Tawi-Tawi and is now serving the far-flung underserved communities in the island barangays. However, there are still remaining challenges and opportunities that can best be addressed by a more focused effort on health system development. However, there still are remaining challenges and opportunities that can best be addressed by a more focused effort on health systems development.

Decentralization has fragmented the national health picture into a mosaic with over 1,500 pieces and continues to present enormous management challenges. Fifteen years after decentralization, the management capabilities of LGU staff and health providers are still lacking in many areas – with weaknesses in health information, procurement and logistics management, financial management and reporting. Governance is not strong and many barriers impede good human resource management. LGUs frequently lack financial resources to fund health services adequately. Supervision of local health providers is not systematized and the district health system that had a network of barangay health stations reporting to rural health units which in turn were supervised by a technical team of a designated district hospital has dissolved – although attempts are currently being made to revive the system.

Emigration of health professionals is now a real challenge but is seldom articulated by LGUs, despite its increasingly evident impact on service quality and performance requirements for accreditation for social insurance. The annual attrition among medical doctors and nurses in the public sector is running at 20% in some LGUs and there are estimates that the number of physicians and nurses working in the country will be halved within the next five years. The problem is particularly acute in rural areas: the distribution of health professionals in the country could now be a deterrent to access to appropriate health care by the poor, since only 10% of doctors and dentists, and 35% of nurses, now practice in rural areas. Current investments in technology transfer and human resource development by foreign-assisted projects could be easily offset by these trends in human resource movement and distribution.

There is evidence that LGU health services are not being adequately utilized by the poor. The Filipino Report Card on Pro-poor Services (2002) indicated that only 70% of the poor used health facilities, while 75% of the middle-income and 82% of the rich did so, despite a corollary survey showing that 32% of poor adults were sick compared to only 19% of rich adults. The Report Card also showed that the poorest 30% turned to traditional healers 40% of the time while middle-income households are twice as likely to use government hospitals than the poor. In response to these trends, LGUs have generally been slow to segment their markets and try to focus their resources more on those who really need subsidized public care. This issue is now being forced on the LGUs by the withdrawal of donated contraceptive commodities and there are indications that many are beginning to react positively by planning to buy contraceptives directly and creating the necessary budget line item to facilitate this. But this developing trend is not yet visible outside FP.

The DOH's Health Sector Reform Agenda (HSRA) – and its recent conceptualization into the *Four*mula *One* program – represents a significant opportunity for any new assistance project to tackle these remaining challenges. As the lead agency for health, the DOH has crafted the reform agenda,

reorganized its central office according to expected functional and administrative changes and has begun studies on the applicability and acceptability of the major strategies recommended for health sector reform to take place. This program focuses on LGUs and improving their health delivery capabilities. Furthermore, many donors and their associated assistance programs are beginning to coalesce around the HSRA and a virtual sector-wide approach is emerging. This will give much-needed critical mass to the effort aimed at strengthening LGUs' health performance, although the initial effort focuses on just 16 of the country's 79 provinces.

A second current opportunity is represented by the increasing formation of Inter-Local Health Zones (ILHZ). Many LGUs, often those in provinces with a governor strongly committed to the health sector, have agreed to group themselves into ILHZs which allow for the movement of resources, including financial, among member LGUs. Experience with this kind of collaboration has thus far proven effective in addressing gaps in service delivery, problems in training and difficulties in supervision by a higher technical authority. Standardization of approaches, sharing of best practices and pooling of procurement to give greater purchasing leverage are future opportunities offered by ILHZs, which are a potentially effective counter to the fragmentation that decentralization produces.

Specific Problems to be Addressed

In addition to the problems addressed in the original DAAD, the seven components of Intermediate Results 1-4 in the USAID strategic framework (Annex 1) remain a legitimate basis for the re-design of the current development activity: while considerable progress has been made on many fronts since the framework was completed, there is still significant unfinished business within each component.

Many management systems remain weak and poorly understood. Local health officials have limited exposure to LGUs' formal management systems as well as the informal relationships that form part of the local governance structure. For example, few health officials truly understand the process used by development councils to prioritize projects for 20% development fund financing. Just as few have a mastery of the formal and informal bargaining processes needed to secure an appropriate share of the local budget for health. Not many are in a position to present convincing and concise information on health and population problems to the local chief executive, sanggunian members or even their peers. After almost 15 years of decentralization, there is still a need to integrate local health staff fully into LGU operations.

Health information is often sparse, which makes both planning and performance evaluation difficult; staff are not well versed in analyzing data that does exist and using it for evidence-based decision-making. Many local health boards, through which citizens' feedback on health service delivery could be articulated, are dormant. Simple participatory planning and processes are often absent, allowing local finance committees to operate unilaterally. Financial management and reporting systems are proving too inflexible to cope with health service financing through insurance coverage; procurement and payment processes are cumbersome, requiring multiple and repeated authorizations before transactions can proceed.

A persistent problem has been the overlap of clientele of cities/municipalities and provinces. Cities (including the highly urbanized and independent component cities), especially those with inadequate or no hospitals of their own, rely entirely or in part on provincial hospitals, causing provincial governments in effect to subsidize the city's health operations. These gaps and imperfections in LGU management systems distort local priorities (often to the disadvantage of the health and population sectors), hinder the allocation of appropriate health budgets, fail to reduce the cost of health commodities, impede the effective delivery of health services and muffle local citizens' feedback on health problems.

Some new systems need to be established. These include systems to guide the operation of ILHZs, which are to figure prominently in the implementation of the DOH's *Four*mula *One* program as well as processes to systematize the identification of indigents to qualify for insurance coverage.

Many LGUs continue to under-fund the health sector. Many of the LGUs which *are* committed to expanding their health and population programs complain that they need more funding from the national government – which is generally unavailable. Most therefore over-rely on their two main sources of revenue – IRAs and local property taxes – which typically account for 85-90% of local income. The first of these is largely beyond LGUs' control and the latter suffers from poor revenue collection processes. There is a growing need to promote the adoption of cost recovery schemes and the passage of local ordinances authorizing the imposition of fees on non-indigent clients, and to diversify revenue sources further by exploring less obvious sources. Few LGUs are aware of these alternative sources and even fewer are trying to exploit them. For instance, many are unaware of credit packages offered through bilateral agreements with donor countries. For example, loan funds provided by the German government through KfW are under-utilized. Very few of the LGUs seem to be aware of the existence of such funds and their purpose, nor are all LGUs yet aware of the opportunities posed by the indigent insurance coverage program as a means of cost recovery.

Local policies and practices on serving the poor need strengthening. Local health officials as well as local chief executives agree that a non-targeted approach to health service delivery contributes significantly to the strain on local resources available for health. Many health officers manning health facilities however still find it difficult to turn away local citizens whom they know are capable of paying for services rendered or commodities handed out. Although some have begun the process of referring such clients either to private clinics or public cash counters, the average health facility health staff is unlikely to differentiate voluntarily between a financially capable client and an indigent: there is a need for clearer policy and guidelines to give service providers more confidence in making such difficult decisions. The introduction of PHIC's indigent insurance coverage program is providing an opportunity to segment clients so that a more targeted approach to health service delivery can be used. LGUs need assistance to make this happen more widely.

Turnover of local health workers remains high. In one year alone, the provincial health office of Bulacan lost a dozen midwives to overseas contractors. Many provincial doctors across the country are taking up nursing courses in the hope of landing better-paying jobs abroad. Most LGUs are resigned to the possibility of more turnover and staff losses but few are taking steps to mitigate the situation. While it may be impossible for LGUs to match the incomes promised by overseas employment, there are avenues to improve the package of economic incentives available for health workers – not only through the full implementation of the Magna Carta Law but also through more flexible financial management and personnel policies. For example, many LGUs have adopted local ordinances allowing part of the income generated from claims against insurance to be allocated for health workers. On the matter of flexible personnel policies such as allowing local doctors to practice their profession in their private capacity, national government needs to be consulted. Other measures to reduce local health worker turnover include opportunities for academic scholarships, or further training abroad or in universities in Manila.

Few local chief executives are yet strongly committed to the health sector. Recent government policy has clearly transferred political responsibility for population programs to LGUs. The LGU response has not been consistent – both because this remains a charged political issue in the Philippines and because population size carries a 50% weight in the formula for determining IRAs. Outside the population field, many local chief executives lack the requisite information and advice on such local health problems as micronutrient deficiency and its impact on maternal and child health, the extent and causes of maternal and infant/child mortality, the persistence of TB and the potential dangers posed by laxity in the control of HIV/AIDS. In the case of TB, several local chiefs of hospitals have been alarmed by the increase in incidence of multi-drug resistance. In addition to the inability of local health offices to communicate well

with their leaders on these issues, most LGUs have not installed information and performance monitoring systems that should alert LGU officials on the state of health of their constituents.

National policy support for LGUs' health activities needs improvement. Decentralization of responsibility for health created many new policy issues as LGUs struggled to maintain standards of health care and coverage. Most of the major policy issues have been identified over the last 15 years but many still remain to be resolved. Prominent among these is financing: LGUs' health efforts remain under-funded and LGUs in general remain dependent on too few sources of revenue which are mostly not under their control. Strengthening of national health insurance through PHIC is part of the solution to this issue but suffers from its own policy barriers which have slowed both accreditation of and reimbursements to health facilities.

Improved financing is part of the wider HSRA in the Philippines and the *Four*mula *One* policy is designed both to simplify and hasten the reform process. There is a need to detail policy guidelines to govern elements of the *Four*mula *One* program that will be beneficial to LGUs. Among these are guidelines on the operation of ILHZs, particularly with respect to joint procurement and project implementation. There is now enough experience to form the basis for such guidelines. Other policy gaps include the need for rationalizing the DOH's materials management systems as well as its process for allocating public health commodities to LGUs.

Procurement is another important policy issue, since decentralization has fragmented the public sector's purchasing power and raised unit procurement costs. Creation of ILHZs may well help to resolve this issue but is itself a subtle process with strong political barriers as authority and responsibility is shared between LGUs. USAID's progressive withdrawal of donated contraceptives complicates this picture. LGUs are faced with not only transferring large numbers of FP clients into the private sector but also finding ways of protecting poor clients, all within a limited time period. At the national level they need help in finding new sources of low-cost supplies of contraceptives, so they can afford to buy stocks for free distribution. At the local level, the challenge is to be able to explain the need for contraceptive self-reliance to the local chief executive and the sanggunian, and then extend that discussion to cover other commodities.

ARMM presents its own policy pressures, stemming both from its unique governmental structure and all the special compliance issues which that raises, and from the elevated levels of poverty and weak health indicators in the region. In addition, there is a host of lower-level policy, process and regulatory issues requiring national attention, ranging from utilization rates of hospitals compared

with primary care facilities to the role and administration of ILHZs and enforcement of regulations requiring prescriptions before dispensing essential drugs.

III. Project Description

This section provides more detail and describes more clearly the activities that will be implemented under the components authorized in the original DAAD. It also updates the information contained in the original DAAD, e.g. current donor activities including USAID projects such as PRISM, the Department of Health's reformulated health sector reform activities known as *Four*mula One, and a focusing of LGUs to be covered by the Project.

A. Project Objectives and Strategy

The scope of the HSD Project covers systems strengthening, improving service provider performance and building advocacy capabilities at the LGU level, and promoting policy change in support of LGUs' health objectives at the national level. HSDP is the Mission's primary activity in the health sector that directly supports IR1, "Strengthened Local Government Provision and Management of Family Planning and Selected Health Services" and IR4, "Policy Environment and Financing for Provision of Health Services Improved." The Project's objective is to strengthen LGU commitment to and support for public health services and LGU capacity to provide and manage quality health services sustainably – especially FP, MCH, TB, HIV/AIDS services, and other emerging and re-emerging infectious diseases such as AI, malaria and SARS.

This includes building the capacity of NGOs and civil society to advocate successfully for good health services. It also includes empowering LGU staff and building their capacity to:

- Gain commitment from public officials for improved health services.
- Justify and obtain adequate financing for improved health services.
- Analyze the health needs of the local population and the resources available to meet those needs, including staffing resources.
- Design, adapt and use LGU systems to meet existing needs, including improvements in service provider performance.
- Improve continuously or create LGU systems to meet emerging needs.

Under this Project, USAID seeks to ensure that sufficient high-quality health services can eventually be sustainably provided, managed and financed by local governments without external assistance. The focus on sustainability has several implications. First, the contractor will work with LGU staff in a participatory manner to determine jointly the LGU clients' needs and to respond to them. Second, emphasis will be given to building both the confidence and the

capacity of LGU staff to carry out the functions listed above. Third, the contractor will work with LGU staff to strengthen their ability to improve their own systems, rather than just improving the systems themselves or simply delivering contractor-designed systems.

Given that USAID wishes to maximize national-level impact, the Project will work with approximately one third of the non-ARMM LGUs over its life. (The new ARMM Health Project will be working with the ARMM LGUs). The Project must therefore use a "wholesale" rather than a "retail" approach in three broad phases. First, an orientation phase, starting at the provincial level to gain the buy-in and commitment of governors, who can influence the buy-in and commitment of the mayors in their province. The support of the various Leagues will also be valuable in encouraging active participation from groups of LGU officials and their staffs. Other USAID projects will be invited to join in this planning stage so that a concerted USAID response becomes possible. Second, a planning phase, when activities are identified, planned and costed, followed by the third, roll-out phase. This three-phase approach may need to be repeated each year in LGUs requiring substantial support.

The LGUs that will receive assistance will be located in 20-25 provinces to be chosen by the Project in consultation with USAID and the DOH. Criteria for identifying the provinces will include:

- Interest in and apparent commitment to health activities by the local chief executive.
- Population size.
- USAID's budget constraint.
- Support for *Four*mula *One* convergence provinces.
- Reasonable regional balance.
- Size of the remaining health and FP challenge.
- Level of poverty.
- Estimated TB incidence rate
- Risk for Avian Flu
- HIV-AIDS sentinel site

An illustrative list conforming to these criteria would include some of the following provinces:

Figure 1. Illustrative List of Focus Provinces for the HSD Project

Agusan del Norte	Aklan	Albay
Aurora	Bukidnon	Bulacan
Cagayan	Capiz	Catanduanes
Davao del Sur	Leyte	Negros Occidental
Oriental Negros	Nueva Ecija	Isabela
Misamis Oriental	Pangasinan	Saranggani
Sorsogon	Surigao del Sur	Tarlac
Zamboanga del Norte		

Some LGUs are more advanced than others in their ability to provide and manage their public health services sustainably. Since the needs of each LGU will be unique, the contractor cannot create a single model for systems strengthening and capacity-building. Rather, the work will be tailored to individual LGUs (or, depending on their homogeneity, ILHZs) and their needs. However, in order eventually to institutionalize LGU capacity-building, the contractor must develop a replicable methodology for working with LGUs to strengthen their capacity to create, adapt and manage their own systems – a methodology that can also be used by other donors in the provinces in which they are working.

Much of the LGU "coaching" that will take place to help LGUs tailor their systems to meet their needs will be provided by existing local, provincial, or regional organizations. These could include regional DOH offices, provincial health offices, universities and training institutions, management consulting firms, and NGOs with well-developed advocacy or public health capabilities. The Project will work with LGUs to help them identify appropriate sources of training and mentoring and will contract with these organizations to provide ongoing assistance to LGUs – and any limited institutional strengthening needed to enable the organizations to play this role. Since a primary objective of the Project is to create sustainable ways for LGUs to improve and upgrade their systems continuously, the Project will experiment with paying for such training and coaching assistance by matching Project funds with LGU funds. As a side benefit of the Project, these coaching organizations will also hone their own

training skills and will be able to function as "replication agents," eventually introducing the Project's policy, advocacy, and systems strengthening methodologies to other non-Project LGUs.

Efforts to prevent and control infectious diseases will focus on strengthening the capacity of LGUs to plan, manage, and implement appropriate health services. The project will interphase with TB/emerging infectious diseases activities to strengthen and facilitate LGU AI preparedness planning in selected provinces depending on the level of risk, including training on basic preparedness measures, community and hospital-based prevention efforts and developing plans and systems for rapid response capacity for AI at the barangay levels.

The follow-on USAID/Philippines strategy addresses the challenges in creating and maintaining a viable HIV/AIDS response in a country that has consistently maintain low prevalence rates despite demonstrable risk factors. The strategy focuses at clusters of contiguous highly urbanized localities where the HIV epidemic had gained a toehold. The strategy's largest component remains prevention of HIV infection and this component supports a geographically focused coverage in the following six areas of the country , namely clusters of contiguous localities comprising:

1. The Clark Development Zone;
2. Metro Manila;
3. Metropolitan area of Cebu;
4. Iloilo-Bacolod area;
5. Davao-General Santos corridor; and
6. Zamboanga City

It is expected that systems strengthening and capacity-building will proceed in waves over the course of the Project, starting at a beginning level for some LGUs and at a more advanced level for others. Therefore, the Project will need to work with some LGUs for only 2-3 years and with others for longer.

Although the bulk of the work will be at the LGU level, the Project will also provide assistance in changing national-level policies, rules and regulations that impede LGU provision of public health services. Much of this work will "bubble up" from the Project's work with LGUs, particularly when it becomes apparent that troublesome policies, regulations and official procedures at the national level are impeding the provision and financing of health services at the LGU level. In such cases, the Project will carry out a series of advocacy activities at the national level – eg packaging and presenting data to inform national-level policymakers about changes that need to be made, finding and supporting national-level champions within the public sector, bringing policymakers together to dialogue about needed changes, and providing whatever assistance is needed

to draft changes in policies, rules and regulations for approval by the appropriate national bodies.

B. Project Components

Under this supplemental DAAD, the three components described in the original DAAD are being reorganized into two components to closely align them with the SO 3 results Framework: Component 1 (Advocacy/Promotion for Local Level Support and Commitment to Family Planning and Health Services) and Component 2 (Strengthening the capacity of LGUs to provide FP/MCH/TB/HIV-AIDS Services) are being merged into Component 1 (LGU Systems Strengthening) under this supplemental DAAD. Component 3 (Policy) will become Component 2 under this supplemental DAAD.

HSDP's two components, described below, broadly align with SO 3's strategic results framework. Component 1 reflects the 4 sub-IRs under IR 1 in the framework. Component 2 draws together the various strands of policy work that

will be needed to address the 3 sub-IRs under IR 4 and includes policy issues arising within ARMM. Gender issues cut across all of the components and HSD Project will need to ensure an appropriate gender sensitivity when preparing its detailed work plans.

1. Component 1: LGU Systems Strengthening

1.1. LGU Management Systems

Under a decentralized structure of government, the effectiveness of health service delivery depends strongly on efficient and effective local government management systems. These systems include information generation and analysis, long- and short-term planning, financial management including budgeting, behavior change communications, procurement and logistics management, quality assurance and supervision, management of human resources, performance evaluation and monitoring. The HSD Project will work with LGUs to assess existing systems such as these and to strengthen them where necessary.

The expected outcomes from this work include, but are not limited to, at the LGU level:

- More evidence-based decision-making as health information flow and analysis are improved.
- Better linkage between long-term strategic thinking and annual work planning as a result of more regular and systematic planning.

- Local health officers and staff are more confident in presenting their population and health plans and budgets before their local chief executives and Sanggunian.
- Better coordination between, and management of, donor programs as donors appreciate more clearly local priorities and needs through stronger planning.
- Local chief executives, Sanggunian members and other concerned officers of the LGU are better apprised on health issues, programs and projects. More and faster informed decisions are made.
- More assured flow of essential drugs and commodities to health facilities based on better stock management, forward ordering and procurement processes supported by more complete data on logistics management.
- More robust governance structures with the roles and relationships between the various levels – e.g. mayor, Sanggunian, local health board, municipal health officer – clearer and better utilized by each party.

In seeking these outcomes, the HSD Project will address three main challenges at the LGU level:

- Many local (and even regional) health officials are still unfamiliar with the operation of local government management systems: as a result, they often miss the opportunity to make the systems work effectively for the benefit of the health sector. The HSD Project will provide formal and informal venues for local health officers and staff to improve their mastery of the management systems, through skill-building, process familiarization and development of leadership skills based on this new knowledge and confidence.
- Many local government management systems are either flawed or inadequate. For example, a recent European Union-funded study observed that, from the issuance of a purchase request to payment for the purchase, a Governor's approval is required three times and the documentation requirements are extremely cumbersome. The HSD Project will enable health personnel staff to define and remedy systems flaws that adversely affect health service delivery.
- Coordination between the various levels of LGUs, the DOH and external donors remains weak. While coordination at the national level is now well-established, systems to coordinate the effort at the regional and provincial levels need to be installed. The HSD Project will work with LGUs, the Centers for Health Development (CHDs), Commission on Population, regional and provincial offices of PHIC, and USAID and other donor projects to develop appropriate coordination mechanisms.

Illustrative activities to be pursued will include, but not be limited to:

- Sharpening the skills of local health officers and staff in analyzing information and data and design ways of making the processed information easily understandable to decision-makers.
- Supporting development of such governance structures as ILHZs to reduce the fragmentation of systems that have resulted from decentralization.
- Training RHU and hospital staff and officers, particularly those in the accredited facilities, in financial and records management to enhance cost recovery efforts.
- Apprising local health officials and staff thoroughly on the budget formulation process and in using such knowledge to facilitate appropriation of resources to the health and population sectors.
- Assess the effectiveness and sustainability of the community-based monitoring and information system (CBMIS) and develop/install less expensive alternatives.
- Design and install processes to be used for ILHZ operations.

Indicators will be developed by the HSD Project to measure performance under this component. An illustrative list of indicators would be:

- Number of LGUS with health sector investment plans.
- Number of LGUs with established health information systems.
- Number of health-related ordinances, resolutions and executive orders issued.
- Number of LGUs with functional, effective procurement and distribution system for essential drugs and commodities
- Number of LGUs with function inter-local health zones
- Number of LGUs that are Sentrong Sigla certified.

1.2. LGU Financing for Health

Financing of LGU health services is an important system that will be addressed by the HSD Project. The key objective for an LGU is to diversify funding sources in order to increase the amount of financing available for health. The main outcomes sought under this component include:

- Number of LGUs spending at least ___% of total public expenditure for health.
- LGU awareness of alternative sources of funding is increased.

- The mechanisms for accessing funding from new sources are better understood by LGUs.
- Barriers at the LGU level to diversifying funding sources are identified and removed.
- More and different sources of funding for health activities being tapped by LGUs.
- More funding overall is available and utilized for the health sector.
- Improved utilization of scarce financial resources through better financial management and budgeting processes which, for instance, allow LGU managers to know their expenditure position against budget in a reliable, timely and accurate manner.

Most LGUs rely on IRAs for around 65% of their annual funding and real property taxes for maybe another 25-30%; most have problems with property tax collection, with the actual collection rate (around 60%) well below the revenue theoretically available. The education sector has an entitlement to a fixed share of property tax collected, a privilege not shared by health. In the case of the health sector, the balance is made up from 'non-traditional' sources – largely PHIC reimbursements at present, although these are slow to start flowing once a facility is accredited to receive them. There are alternative revenue sources, including Municipal Development Fund and donor loans, donations from Overseas Filipino Workers or groups of expatriate Filipinos and possibly national lottery proceeds. User fees can be contemplated for those who can afford to pay if the LGU is able to segment its market accurately. Existing revenues can be stretched further by good cost accounting and cost controls and negotiation on behalf of the preventive health sector can divert existing funds from other uses – either other sectors or non-preventive care within the health sector. Some LGUs are already experimenting with revolving funds – started by PHIC reimbursements or donations and backed up by user fees – as a means of stretching an annual budget into later years.

Illustrative activities to be pursued under this component include, but are not limited to:

- Assisting LGUs to develop medium-term financial plans over maybe three years to identify expenditure needs and therefore revenue requirements for health.
- Introducing LGUs to different funding alternatives and opportunities, based on available sources and best practice observed in other LGUs.
- Helping LGUs to develop a financing strategy which will accommodate the medium-term revenue requirements.
- Assisting health managers to know how best to work with LGU finance managers in tapping alternative funding sources.

- Developing models of how revolving funds can work on different start-up bases within an LGU and sharing these models with both health and finance staff.
- Encouraging LGUs to undertake market segmentation and demonstrating how it can be done cost-effectively.
- Assisting LGUs to review the efficiency of their financial management so that health managers are better able to control their existing budgets through reliable, timely and accurate reporting.
- Assisting LGUs to explore the benefits and techniques of performance-based budgeting as a means of making better use of scarce financial resources.

Example indicators that can be used to measure progress under this component include:

- Percentage of the health budget financed through IRAs and property taxes.
- Percentage of LGU health facilities accredited and receiving PHIC reimbursements.
- Number of LGUs tapping loans or donations for health activities.
- Percentage of LGUs who have completed market segmentation as a basis for introducing user fees.
- Percentage of LGUs employing user fees for non-FP services.
- Number of LGUs using revolving funds for some aspect of their health activities.

1.3. Service Provider Performance

Service provider performance is a crucial part of ensuring high quality health care provided by LGUs. Since the change of health management responsibility under decentralization, service providers in district hospitals, RHUs and barangay health stations have become somewhat detached from the supervisory systems and quality assurance procedures that used to prevail under the old, centralized and vertically integrated approach. Furthermore, LGU budget pressures and competing budget priorities mean that government health workers still have a fixed, low and relatively flat wage profile and there are even fewer opportunities for career advancement than before. The number of physicians and nurses in many LGUs has steadily decreased since the mid-90s, with nurses leading the exodus of local health workers to jobs overseas.

The service provider outcomes sought under this component include, but are not limited to:

- Improved staffing levels in LGU health facilities, at or approaching WHO standards.
- Better local working conditions and payments for doctors, nurses and midwives, including an incentive component to enhance performance.
- More active administration of staff benefits to ensure that staff actually receive their existing entitlements.
- Increased opportunities for technical training.
- Stronger supervisory systems so that quality is monitored more closely and more regularly and is supplemented by routine surveys of client satisfaction.
- Greater awareness among local chief executives of the staff turnover and increasing emigration issues, so that greater policy and planning focus is provided in these areas.

The HSD Project will pay special attention to the barangay health workers, since their participation is critical to health success. The HSD Project will explore ways to maximize their performance as effective outreach workers – such as providing competency-based training for the technical aspects of family planning and child health, appropriate performance incentives (e.g. transportation allowances or uniforms) and regular supervision of the workers by the barangay midwife.

This component provides one of the most direct linkages between strengthening of LGU systems and advocacy capabilities on the one hand and improved health outcomes for the nation on the other. If these service provider outcomes can be achieved, then the HSD Project is expected to help service providers contribute to priority health outcomes, including:

- Rising contraceptive prevalence rates.
- Higher TB detection and cure rates.
- Increased skilled attendance at births.
- Increased uptake of antenatal and postnatal care.
- Higher immunization coverage.
- Greater awareness of HIV and how to prevent its transmission.
- Increased prevalence of breastfeeding.

All of these outcomes will be pursued through a combination of activities, including:

- Facilitating surveys of refresher training needs based on current intervention-specific service delivery problems, primarily for staff serving at the RHU and barangay health stations.

- Identifying the most appropriate organizations to provide refresher training to staff from each of the HSD Project's target provinces – including CHDs, provincial health offices or other organizations.
- Working with LGUs to ensure that service provider training costs are progressively built into LGU health budgets.
- Assisting selected training partners to improve their readiness to provide training.
- Working with LGUs to help them identify staffing patterns and desired staffing standards and develop strategies for bridging any gaps.
- Helping LGUs to review current staff benefits and their administration in order to simplify the existing package and develop new incentives aimed at improving morale, reducing staff turnover and directing existing staff towards serving those most in need – for example, provision of non-monetary incentives such as a free, comprehensive health insurance package for health workers and educational package for the children of those assigned in difficult areas.
- Encouraging compliance with the 2002 nursing law increasing the salary range for nurses and for faithful provision of other benefits and wages provided by existing laws.
- Cross-training of different staff cadres in response to the high emigration and turnover rates.
- Examining how supervision is currently performed and work with LGUs to explore new strategies for increasing both the thoroughness and regularity of staff supervision, tied to the new incentives to be developed.
- Assisting LGUs to design and install inexpensive systems to measure the performance of health personnel and make them more accountable to the community.
- Proposing new approaches to measuring and surveying client satisfaction and tie this to staff incentives.
- Helping health staff to develop advocacy and health education packages for LGU managers consisting of information materials, meetings or public forums that will improve their understanding of the service provider performance issues.
- Seeking commitments to augment the wages and benefits of local service providers by long-established associations or foundations – e.g. the Philippine Nursing Association, Philippine Medical Association, the Integrated Midwives Association, and overseas Filipino workers through the Overseas Workers Welfare Administration.

Examples of indicators to be used for this component are:

- Number of initial client visits and return visits to public health facilities increased.
- Number of organizations certified/accredited as training providers.
- Percentage of service providers who underwent training in the last three years.
- Percentage of LGUs paying directly for service provider training.
- Percentage of surveyed service providers receiving wages and benefits according to the Magna Carta for Public Health Workers and according to any new regulations on provision of incentives.
- Number of local organizations and institutions committed to provide non-monetary incentives and benefits to LGU service providers.
- Number of LGUs passing new ordinances to improve or protect health staff's working conditions or benefits package.
- Frequency and quality of monitoring and supervision activities at LGU health facilities.
- LGU health personnel attrition rate.
- Client satisfaction scores.

1.4. Advocacy on Service Delivery and Financing

USAID recognizes that public sector provision of quality health services depends on the commitment of public officials to invest in health and on policies that promote both the supply of and demand for health services. Therefore, advocacy and policy are also an important aspect of the HSD Project. Under this component the HSD Project will work with LGU staff, public sector champions and civil society to strengthen their ability to advocate for sufficient funding and a favorable policy environment for public health. The outcomes of such work will be:

- Increased understanding by LGU officials of the importance of public health for the development and welfare of their LGU.
- Formulation and dissemination of policies and public statements favorable to the provision of quality public health services at the LGU level.
- Approval of LGU budgets sufficient to meet public health needs.
- Active promotion of public health services by LGU officials, especially to the poor.
- Increased confidence and ability on the part of public sector health staff to advocate with LGU officials for their budget and other needs, including the ability to identify, analyze and present data to support the issues for which they are advocating.

- Increased ability of NGOs and civil society to advocate for public health services, especially for the poor, including the ability to identify, analyze and present data to support the issues for which they are advocating.
- Increased ability of NGOs to monitor the quality of public health services and report areas with which they are dissatisfied.

In most instances it will be necessary to gain the trust and buy-in of the governor and provincial health and population officials before working at the city or municipal level. The HSD Project will also touch base with the various Leagues to keep them apprised of each area of work that will be undertaken and to gain their support and buy-in as needed. Although most of the technical assistance for policy and advocacy provided under this component will be at the city or municipal level, the Project may also provide such assistance at the provincial level in instances where it will pave the way for more effective policy and advocacy work at the city/municipal level.

At the local level, the HSD Project will work with LGU officials, including the mayor, the budget officer, the planning officer, the Sanggunian Bayan, and others whose decisions affect the provision of public health services. The HSD Project will also work with LGU health staff to increase their confidence and ability to advocate for their programs. And, finally, the HSD Project will identify NGOs and civil society representatives and strengthen their ability to advocate for public health issues in close collaboration with the Health Promotion and Communication (HPC) Project. Civil society advocates are important conduits for public health in two directions, both from the community to public officials, and from officialdom back to the community. In the former direction, civil society advocates can voice the needs of the community, particularly the poor, and insist that public officials meet those needs. In the latter, they can serve as sources of information on health services that are available to the community and can educate the community about the importance of using such services, for instance the benefits of utilizing the services of skilled providers for childbirth.

The policy and advocacy work will be carried out in a participatory fashion, focusing on the needs and wishes of the client, including LGU officials, health staff or civil society representatives. The HSD Project will provide assistance and advice on how best to bring about policy change or how best to advocate effectively – i.e. the process and skills for policy change and advocacy – but the policy and advocacy issues to be addressed will be identified by the parties concerned.

Illustrative activities under this component include, but are not limited to:

- Technical assistance (TA) for health service staff on choosing and packaging public health information to inform and gain commitment from public sector champions.
- TA for health service staff on presentation and advocacy skills, primarily drawing on the expertise from the Health Promotion and Communication (HPC) Project.
- Assistance to local officials on creating or changing policies that affect provision of public health services.
- Identification of NGOs and civil society advocates interested in improved public health.
- TA for NGOs/civil society on advocacy skills – e.g. identification of targets, development of advocacy strategy and messages, ability to understand and use appropriate data, and presentation skills.
- Small grants to enable NGOs to disseminate health service information to the community.

To promote replicability and sustainability the HSD Project will identify and work with local academic or other institutions that can provide advocacy and policy assistance to LGUs. The HSD Project will also identify promising health sector staff and civil society advocates and provide training-of-trainer sessions so they can then provide policy and advocacy training to other LGUs in the province.

Illustrative indicators under this component include, but are not limited to:

- Number of LGUs with more comprehensive and well-presented plans and budgets.
- Number of LGUs in which health advocacy strategies and messages are developed.
- Number of LGUs in which NGOs advocate to the community for increased use of public health services, especially among the poor.
- Number of LGUs in which mayors publicly promote the value of improved public health.
- Number of LGUs in which the budget proposed by health sector staff is approved.
- Evidence of community input to deliberations of local health board or sanggunian bayan.
- Evidence of LGU input to health sector program or budget deliberations at provincial level.
- Favorable positions taken by the Leagues on public health issues.

2. Component 2: Strengthening Health Sector Policy Formulation Systems

The HSD Project will need to tackle a variety of policy issues which are still constraining health performance. Most of the national policy issues are known at this stage, especially those stemming from decentralization in the early 1990s, so the focus is more on issue resolution and implementation of policy change. The main areas of policy work for the HSD Project will be in health financing, implementing other aspects of health sector reform, ensuring secure contraceptives supply in the face of withdrawal of donated commodities, and resolving particular policy barriers to health within ARMM. The scope will include both national policies/laws with universal impact on health and narrower regulations which may be internal to one organization (e.g. DOH or PHIC) which also affect specific aspects of health care and delivery.

With respect to the SO 3 results framework, the main issue under sub-IR 4.1 is contraceptive supply. The DOH issued Administrative Order 158 in 2005 introducing a policy of contraceptive self-reliance (CSR) among LGUs nationwide in the face of declining donations of contraceptive commodities. Problems in financing the policy and in sourcing new supplies of contraceptives have since been identified by many LGUs. Surveys have shown that over half of FP users availing of government-subsidized contraceptive supplies can in fact afford to pay and continuing government subsidies in the face of declining supplies of free contraceptives threatens to deprive the poorer sectors in the community of their only access to contraception. Thus, the supply of contraceptives at public health facilities needs to be improved in terms of volume and allocative efficiency.

Many of the national laws, regulations and policy-based programs needed to support effective health service delivery at the local level are in place; these are the focus of sub-IR 4.2. Among these laws and policies are the Generic Drugs Act, Pharma 50 (parallel importation), Botika sa Barangay, the Local Government Code of 1991, the National Health Insurance Act, the Philippine AIDS Prevention and Control Act of 1998 and its implementing rules and regulations and the HSRA, now re-formulated as the *Four*mula *One* Program of the DOH. This component of the Project will focus on identifying and filling remaining policy, legal and regulatory gaps in national level support for health.

LGUs look to many national policy-makers for changes which can improve their financing of health care; mobilizing such additional financing is the focus of sub-IR 4.3. The DOH, PHIC and the Department of Finance (DOF) are the most prominent policy-makers here. DOH regulations affect LGU financing through, for instance, the setting of standards for health care and through the relationship between the DOH and the CHDs.

Standards set by the DOH have to be met through activities financed by LGUs, with little financial contribution from the national level, and many LGUs would like more say over the standards and their financial implications. Expenditure against CHD budgets is controlled by the DOH and so, while CHDs are able to provide training services to LGU staff, they are not able to contribute to small-scale refurbishing of LGU health facilities in need of repair.

PHIC plays an increasingly important role in LGU health financing but the flow of funding depends crucially on accreditations (generally found to a slow process with multiple iterations between the DOH and PHIC) and its ability to reimburse facilities' claims (also found to be generally slow in starting). The DOF has a policy stance which opposes concessionary financing for LGUs – even donor loans to the national government at favourable rates over long periods are passed on to LGUs at commercial rates. Municipal Development Fund loans come with a small grant component and therefore constitute a mild concession in terms of loan cost – but most LGUs find the Fund's procedures too slow and cumbersome for such loans to be considered. National level policy on limiting employment costs' share of LGU budgets is another irritant in a service-intensive sector like health.

National Level Policies Affecting ARMM

The ARMM Regional Government (ARG) is a special (one-of-a-kind) type of local government unit existing only in the region. Provincial, city, municipal and barangay governments in ARMM are generic local government units similar to their equivalents in non-ARMM areas. A critical part of governance, service delivery, regulations and financing for attaining health goals in ARMM localities depend on the effective performance of government roles and functions shared between the ARG and the other LGUs in ARMM.

Developing the policy environment affecting the shared arrangements between the ARG and component LGUs in ARMM will therefore be crucial to the attainment of health goals in ARMM. Significant part of this policy environment will be set by the workings of the existing political institutions within ARMM, at the ARG level (such as the ARMM Governor, Regional Legislative Assembly, ARMM Cabinet, Regional Economic Development and Planning Board, and the DOH-ARMM) as well as at the component LGU levels (such as the provincial, city and municipal governments of ARMM). An important part of this policy environment, however, is dependent on national government policies affecting all LGUs, including those within ARMM, not the least of which is the ARG.

Focusing on the national government policies affecting the health effort in ARMM, addressing the following issues may create important opportunities for improving the policy environment for better health in ARMM within the next 3 to 5 years.

National Government Policies Affecting Generic Operations of ARMM LGUs

Due to the widespread poverty and under-development of the ARMM localities, its governments' revenues are largely dependent on transfers from the national government. These transfers to ARMM come through two main channels. One channel is the share of ARMM LGUs in the Internal Revenue Allotments based on rules applicable to all LGUs in the whole Philippines. Recent pronouncements from the Department of Finance suggest that the national government may take steps to revise the basis of IRA allocations and these changes (if they do occur) will affect the level of resources available to LGUs in ARMM. The second channel of national government transfers to ARMM is through the budget of the ARG, which is incorporated in the annual national budget (General Appropriations Act). Policies affecting the level, allocation and restrictions in the use of ARG budget, including the budget for health services, will have an impact on the efficiency, effectiveness and equity of region-wide health service delivery through the formal public health system, which is often the only provider of professional health services in many ARMM communities.

Considering the dependence of ARMM LGUs (including the ARG) on revenue transfers from the national government, a key area of policy development is the institutional compliance of ARMM LGUs with generic financial management and administrative safeguards established and implemented by the national government for LGU compliance. There are recurrent reports of widespread lawlessness in local governance practices in ARMM, such as IRA receipts treated as personal expense accounts of some LGU executives, illegal termination of tenured civil servants whenever there is change in local administrations, among others. Improving the overall policy environment affecting compliance with basic governance safeguards across all LGUs in ARMM, together with all other LGUs in the country, might be a promising enterprise. Examples of this work might include the following: enforcement of LGU budget review procedures established and supported by the national Department of Budget and Management; rigorous compliance by LGUs with the accounting and expenditure reporting standards mandated and supervised by the national Department of Finance; regular public reporting of audited annual LGU expenditures enforced by the national Commission on Audit; and basic measures on civil service protection and merit-based personnel

management enforced by the national Civil Service Commission. The approach would be mainly policy advocacy and promotion of compliance with basic rules and regulations, rather than focusing on individual violations or deviant governance behavior.

National Government Policies Specifically Affecting ARMM's Health Sector

Beyond the general governance basics of a fair share of government revenues and lawful stewardship of public resources that are essential to an effective health effort in ARMM, there are other national government policies affecting health effort in ARMM which originate from two important national agencies, namely, the national Department of Health and the Philippine Health Insurance Corporation.

Several key national DOH policies affect the health effort in ARMM. The DOH is embarking on developing a medium-term public expenditure framework for the health sector, which would indicate the levels and uses of national government funds for health over the medium term. Obviously the inclusion of ARMM health needs in this framework is important for ARMM. Furthermore, the DOH is already in the process of implementing a number of policies, which are part of a matrix of policy commitments that is part of an on-going sector loan financed by the Asian Development Bank's health reform project. A cursory review of this matrix indicates that a number of these policies will have an impact on ARMM's health sector. Below is an initial list of national government policies included in the matrix as due in 2005 and 2006 that could have a major impact or consequence in ARMM:

<u>2005</u>

- Commitment of national government subsidy for PHIC enrollment of indigents, including indigents in ARMM
- New policy on rationalizing public hospitals, including hospitals in ARMM
- New policy on expenditure targets for public health spending and performance-based budgeting for priority public health programs, which will affect what health inputs of ARMM health services will be provided by the national government

<u>2006</u>

- New PHIC policy on a more progressive premium structure, likely to affect the cost of PHIC enrollment of ARMM residents

- Revised PHIC benefit package providing higher payments for better quality, likely to affect ability of ARMM providers to obtain higher benefit payments and of ARMM beneficiaries to avail of higher quality care covered by insurance.

The above polices are part of what the DOH has been implementing as the Fourmula One for Health (F1) at the national level and at a number of convergence provinces. While ARMM provinces are not part of the convergence areas, national policies developed under F1 and donor mobilization to support sector-wide coordination are likely to affect the health effort in ARMM in critical ways. Two specific items in the extensive F1 agenda should be noted as important to ARMM. One is the DOH policies on sector-wide performance monitoring, via such mechanisms as LGU score card, tracking of local progress towards attainment of MDG targets, and possible linkage of additional resources to improved outcomes. These policies could have a major influence on the performance-based monitoring of ARMM effort. The other item concerns the DOH policies on promoting sector-wide approach to donor coordination, which would have an impact on the consensus, mechanisms and actual operationalization of donor coordination in ARMM.

Apart from DOH, the PHIC is another arena of policies that affect health effort in ARMM. The widespread poverty and under-development of ARMM suggests that significant health status improvements will partly depend on the region's access to resources necessary to sustain effective and equitable health effort. Part of these resources will flow through national government transfers to ARMM as described above. Another part would be for ARMM providers to access the large pool of accumulated health benefit fund under the management of PHIC. In order to access the national health insurance fund, ARMM residents, including the majority that are indigents, should be enrolled in the National Health Insurance Program. Enrollment, however, is merely the beginning and will hardly be useful without actual use of health insurance benefits, actual receipt of health benefit payments and use of payments to further enhance health services. All these will depend on the policies of PHIC governing enrollment, provider accreditation, benefit coverage, provider payment and use by public providers of benefit payments received. All of these will obviously be considered for nationwide application, as PHIC decides on policies with the whole country in mind; but the differential impact of nationwide policies on ARMM should be an explicit consideration if these policies were to support rather than constrain effective health effort in ARMM.

The main outcomes sought under this component include, but are not limited to:

- The continued allegiance of existing FP users to contraception and the continued expansion of the FP program to include new users, despite the change in supply arrangements. This will include: development of workable strategies for securing contraceptive supplies in all LGUs; successful transfer of those who can afford to pay for contraceptives from free supplies in the public sector to buying contraceptives under a variety of public and private sector schemes; diversification of sources of contraceptive supply to the Philippines market, so that low-cost, unbranded supplies become more readily available.
- Greater clarity in the devolved relationship between the DOH and the CHDs on one hand and between the CHDs and the LGUs on the other, leading to better planning of the LGUs' ability to leverage the full range of DOH capabilities.
- Enhanced utilization and an expanded role for ILHZs as a means of compensating for the fragmentation of effort and systems that decentralization creates.
- Greater national policy support for overcoming intervention-specific delivery problems – such as pharmacies providing TB drugs without prescriptions or midwives feeling constrained on giving injections.
- National policies and regulations which impede expansion of funding sources for LGU health activities are reviewed and selectively amended.
- National policies and regulations which reduce the flexibility of LGUs in making effective and efficient use of their existing financing are reviewed and selectively amended.
- Institutional compliance of ARMM LGUs with generic financial management and administrative safeguards established and implemented by the national government.
- Increased concessionary finance available to LGUs in particular need, especially those in ARMM with the weakest health indicators.

The generic illustrative activities needed to ensure these outcomes include, but are not limited to:

1. Advising partners in identifying policy barriers to as well as opportunities for improving and expanding health service delivery.
2. Facilitating identification of and working with policymakers and stakeholders who are in a position to influence policy change in the identified areas.
3. Developing capacity for advocating for policy change using the results and consensus achieved once the case for change has been demonstrated.
4. Assisting partners in the preparation of policy instruments and policy implementation plan.

5. Assisting partners in strengthening mechanisms or a venue for generating issues and ideas as well as building consensus on necessary and appropriate policies to improve health service delivery.

Beneath these generic activities lie sub-activities very specific to the different policy issues inherent in the outcomes sought above – e.g. contraceptive supply, health financing, role of the ILHZs, etc. Much will be done by LGUs themselves but this component focuses on how the HSD Project can assist national policy-makers to facilitate change – for example:

- Developing a standard approach to client segmentation as a basis for introducing user fees.
- Working with an array of national stakeholders to help them increase awareness among LGU managers of the alternative sources of contraceptives for those who can afford to pay.
- Working with other USAID projects at the center – especially PRISM and HPC – to promote policies and activities that will help clients understand these new sources of contraceptive supply.
- Facilitating pooled procurement of contraceptives and other commodities by several LGUs.
- Assisting in the development of guidelines covering the operation of ILHZs, particularly on matters where national government counterpart support will be needed.
- Assisting in the promotion of policies providing incentives to local health workers. The Project will engage associations of public health service providers – especially RHU nurses and midwives – to develop and advocate for policies that will allow its members to share in the proceeds of local health operations. This will require coordination with the Civil Service Commission.
- Helping to develop policies that will simplify procurement of health supplies. The HSD Project will coordinate with other donors – e.g. the European Union and GTZ – and other USAID projects working with relevant national government agencies on the improvement of procurement policies.
- Helping DOH and PHIC to consolidate and simplify accreditation processes in order to speed up financial flows to LGUs.
- Assisting the Department of Budget and Management craft guidelines to operationalize performance-based budgeting principles at the local level for health planning.

- Exploring opportunities for earmarking revenues for the health sector, especially revenues flowing from taxes on use of 'unhealthy' products like alcohol and tobacco.
- Assisting appropriate ARMM agencies to ensure that LGUs are fully covered by policy changes affecting health, in some cases with preferential treatment in the light of their weaker health performance.
- Ensuring that a venue or mechanism for debating on policy issues, generating ideas, and building consensus on necessary and appropriate policies to improve health service delivery is established to ensure operations in a sustainable manner.

Indicators associated with these activities and which will measure progress towards desirable policy change include:

- Number and proportion of LGUs actually purchasing contraceptive supplies with their own funds.
- Number of new national sources of unbranded or branded contraceptive supplies.
- Percentage of FP clients paying user fees for contraceptives.
- Number of new acceptors and continuing users of modern FP methods.
- Number of LGUs using contraceptive supply initiatives/mechanisms for other essential drugs/ commodities.
- Number of LGUs procuring technical assistance services from CHDs and other appropriate local institutions.
- Number of operational ILHZs and the proportion with combined health budgets.
- Percentage of LGUs with a client satisfaction index in use and regularly reported.
- Number of LGUs that have adopted performance-based budgeting.
- Number of LGUs which have passed new ordinances to reinforce national policies which are only weakly enforced (e.g. covering prescriptions and dispensing of essential drugs).
- Number of amendments to national laws, regulations or procedures attributable to HSD Project activities and efforts.

C. Assumptions, Constraints and Risks

The components described above constitute the basis for the design of the HSD Project but successful implementation depends on various assumptions implicit in the design. The risk of project failure will increase if any of these assumptions prove to be false throughout the project's life. The design assumes that:

- Government policy on FP does not increase constraints on contraceptive supply and use. Current national government FP policy in the Philippines is constrained by well-known cultural and religious issues. An equilibrium currently exists but the contraceptive prevalence of modern FP methods is only 33%, well below that of comparable countries although slowly rising. Were national government policy to harden – or if more LGUs were to adopt local policies constraining FP choice – then the success of many components of the Project would be threatened. In particular, many poor users of FP would probably drop out of the market entirely if policies to protect them from withdrawal of donated contraceptives were not pursued. The HSD Project will need to advocate actively at both national and local levels to guard against such developments.
- LGUs' commitment to health continues to grow. It is clear that even committed LGUs are having problems funding an expansion of health sector activities, and yet not all LGUs are fully committed at this stage. There seems to be an increasing level of commitment among governors of provinces, although the more numerous cadre of city and municipal mayors remains mixed in its views on health. The HSD Project plans to work in 20-25 provinces and among all of their roughly 460 cities and municipalities. This strategy will be threatened if the proportion of mayors committed to health does not continue to increase (or even falls), since the HSD Project's effort would become fragmented and sub-optimal in many provinces. An alternative exists – to seek out individual, committed mayors in other provinces – but would be costly and time-consuming to implement.
- National policies affecting LGU health service delivery are susceptible to change. It is almost 15 years since decentralization and many national policies are still not directly supportive of LGUs' health activities. The HSD Project assumes that this is caused by insufficient focussed effort over a long enough period to date – rather than insuperable barriers to change and that the policy efforts proposed here will be able to achieve desirable change.
- Emigration of LGU health staff can at least be slowed. The pace of staff turnover and emigration seems to be accelerating to crisis proportions; the number of doctors re-training as nurses for overseas employment is particularly worrying. These trends undermine management systems by increasing the proportion of new staff unfamiliar with the systems and reduce quality by lowering staffing levels and experience. The cost of training and building experience in client service and health management will become untenable for already stretched LGUs if these trends continue at the current pace.
- New sources of low-cost contraceptives can be found for the Philippines market. This assumption is essential for the success of contraceptive self-reliance and yet the market will seem unattractive to any prospective new supplier: low margins (since the products have to be low cost) and 1,500 inexperienced LGU customers, often with weak and unpredictable procurement processes and a poor payment record.

- The *Four*mula *One* policy continues for a reasonable period. Health sector reform is a complex process and health is just one of many new areas that LGU managers have to master. The *Four*mula *One* packaging of sector reform has helpfully simplified the issues but now the premium is on continuity so LGU managers can learn and become comfortable with those issues and work with their health professionals to develop a sensible response.

In addition to these important assumptions, there is one overriding constraint which the HSD Project must recognize: time. The HSD Project cannot act independently. It takes time to gain the understanding and trust of political leaders and to get them to the point of allowing the HSD Project to work productively with their health staff. It takes more time to develop a consensual, team based approach to local health issues working through local staff, not just delivering products and moving on. It takes even more time to get budget to support useful changes that emerge from these consensual processes, since decision-makers multiply once budgets are involved. Achieving national policy change in any country on any topic is a slow and subtle process. The HSD Project design emphasizes the use of replication agents as a means of leveraging and quickly multiplying the HSD Project's reach but a fast start-up is going to be needed and a relentless pace of promotion and persuasion thereafter.

D. Synergies with Other USAID and Donor Plans

1. Other USAID Plans

There will be strong relationships between HSDP and other ongoing and new USAID projects in the health sector:

- PRISM Project – PRISM and the HSDP will need to collaborate on contraceptive supplies. As donated supplies end, there is need to migrate clients who can afford to pay for FP services into the private sector or charge user fees for those who continue to use the public sector. PRISM can assist significantly with the migration strategy, helping to foster new avenues for access to private FP services. At the same time, there will be a need to attract new suppliers of low-cost, unbranded contraceptives into the

  Philippines market so that LGUs can afford to buy contraceptives for free distribution. The HSD Project will look to PRISM and possibly DKT Philippines to assist with diversifying the range of suppliers and products at the bottom end of the market.
- ARMM Health Project – While service delivery efforts will be separated by geography, there will an overlap between the HSDP and the new ARMM Health Project on national policy issues. The ARMM Health Project will handle policy issues within ARMM itself – akin to the HSD Project assisting in development of new LGU ordinances outside ARMM. However, the HSD

Project will take on board policy issues at the national level arising from both ARMM and non-ARMM parts of the country. Many of these issues have been identified already.

- HPC Project – This new project will cover behavior change communication (BCC) issues for FP, MCH, TB and HIV/AIDS. This means that needs for BCC assistance – e.g. on BCC campaign design or training on inter-personal communication – to LGUs already working with the HSD Project can be channeled to the partner HPC project as needed. Also, the HSD Project will be involved in advocacy at the LGU-level, mostly on topics associated with *support* to service delivery – e.g. increasing financial flows, promoting adequate budget provisions, ensuring sufficient supplies of commodities, etc. To the extent that the HPC Project is involved in BCC topics directly associated with service delivery – e.g. promotion of exclusive breastfeeding, improving EPI coverage or encouraging condom use among HIV risk groups – there will again be significant convergence of interests between the two projects.
- The TB Control Project – HSD will look to this project for deeper technical TB skills in such areas as multi-drug resistant TB and paediatric TB. The two projects will work closely on delivering these skills as needed to LGUs.

The HSD Project will complement other USAID activities in the private sector – e.g. in FP and TB. While the HSD Project's concern is the public sector, there will be continuing discussion on how to focus the public sector on those who need free and/or low cost service, while ensuring that those who can pay are well cared for in the private sector. This resource allocation issue – leveraging the private sector to ensure that scarce public resources are wisely utilized – will provide a continuing need for dialog between the HSD Project and its private sector counterparts.

2. Other Donor Plans

The Asian Development Bank (ADB) has three ongoing forms of assistance to the health sector: a program loan of $200 million to be used over the period 2005-2007, to finance HSRA activities at the center; a project loan of $23 million, to be used over the same period, to finance HSRA implementation in five provinces (Ifugao, Ilocos Norte, Nueva Vizcaya, Oriental Mindoro and Romblon); a technical assistance grant of $1 million over the same period to assist DOH in conceptualizing and planning its HSRA activities and how best to assist LGUs in implementing reforms.

The World Bank (WB) is working closely with ADB, the European Commission (EC), GTZ/KfW and WHO as it evolves a virtual sector-wide approach to assisting the health sector under the auspices of the HSRA. WB is working in all 16 of the DOH's convergence provinces under the *FOUR*mula *One* initiative. A $100 million WB loan, to be launched in 2006, will include finance for PHIC premiums for the indigent, performance-linked grants to selected LGUs with

acceptable service performance agreements, support for the Bureau of Food and Drugs while it is in transition to increased cost recovery, strengthening central office functions of both DOH and CHDs, and DOH counterpart contributions to EC grants for LGU implementation of HSRA.

The EC is already active in some of the convergence sites and plans to provide a $39 million grant (likely to start in October 2006) available across all 16 convergence provinces to assist with HSRA roll-out by LGUs; the focus will probably be on systems strengthening, especially poverty mapping methodology, LGU scorecards and information systems development. The EC grant will also help fund some strengthening of DOH central functions. GTZ is already supporting HSRA roll-out in three convergence provinces with technical assistance of around $2 million. KfW is planning to launch a $12 million loan for the same purpose in another three convergence provinces during 2006 and will also continue to support the DKT Philippines social marketing of contraceptives through 2008. WHO continues to provide modest technical assistance under its four strategic focus areas: advocacy for health, protection of the poor, health sector reform and reducing disease risk.

The efforts of these and other donors to the health sector (e.g. Japan International Cooperation Agency) imply that considerable donor support will be available to supplement the efforts of the HSD Project. The danger of overlap increases to the extent that HSDP focuses on the DOH's convergence sites. However, even within these sites, there will be plenty of room for all of this proposed donor assistance, with a few cautions: on systems strengthening for LGUs, there will need to be care on information systems, poverty mapping and commodity logistics management to avoid overlap with the EC and WB; work on service provider performance improvement needs to be mindful of the WB-financed initiatives under service performance agreements; national policy and advocacy work will need to take into account what many of the other donors are doing.

IV. Implementation Plan

This section contains the basic elements in the original DAAD and presents only an update of the various management mechanisms recently adopted by the DOH.

A. Project Management

USAID/Philippines will provide the overall program direction, approving the selection of LGUs that will be assisted, and monitoring the approach that is used to ensure that it promotes capacity-building among LGU staff and leads to sustainable provision of quality public health services in the assisted LGUs. This management support will be supplemented by the Mission creating internal

structures to ensure coordination between the HSD Project and other projects in the health program – so as to ensure coordinated planning and other routine interfaces with the target provinces. USAID/Philippines will also be responsible for ensuring that monitoring, evaluation and audit requirements are complied with.

In fulfilling this role, USAID/Philippines and its Cognizant Technical Officer will maintain close coordination and cooperation with the DOH through three main suggested mechanisms which are already under discussion:

- A High Level Consultative Panel will continue to provide overall strategic direction, policy level advice and facilitate cooperation between government agencies, USAID and the HSD Project. The Panel will be co-chaired by USAID and the National Economic Development Authority (NEDA), with the DOH as a Panel member. Other interested bodies – e.g. the Commission on Population (PopCom), PHIC, the Leagues, other government agencies, NGO and private sector parties – may also be invited to join the consultation.
- The National Health Planning Committee. Chaired by the DOH's Assistant Secretary for Policy, the Committee will provide health sector-specific guidance to the Project.
- A Technical Inter-Agency Committee will oversee the Project at an operational level and provide a forum for coordinating and consolidating design, implementation and monitoring of the Project's activities. The DOH, USAID, PHIC and PopCom will be members.

Various technical working groups will also be created as the need arises and ways will need to be found to ensure that LGUs' interests are directly represented as well in the management structure.

USAID's management of the HSD Project will emphasize collaboration and building synergy between this and other USAID projects in the health and family planning sector and will also promote coordination with activities under other

Strategic Objectives as may be programmatically or logistically appropriate. USAID management will also take special care to promote collaboration with advocacy, policy and systems-strengthening activities funded by other donors, particularly those in *Four*mula *One* provinces where other donors are particularly active. The aim is to capitalize on the synergies between the systems that are being strengthened by USAID-funded technical assistance and the investments in health sector management systems, infrastructure and insurance coverage that are being funded by other donors.

USAID Inputs

1. USAID/Philippines

Technical assistance and training. USAID will provide technical assistance and training to implement the project through contractors, grantees and cooperative agreements. For Component 1, assistance to LGUs to strengthen their capacity to advocate, to bring about policy change, to strengthen health systems, and to bring about service delivery performance improvement will be provided in the form of a support package that is tailored to the needs of the LGU. It will consist of a combination of technical assistance and training to improve the provision of LGU public health services. Examples of specific inputs could include expert assistance for developing advocacy skills, for formulating and implementing policies, for improving health facilities management, for developing better health sector financing, for improving data collection and analysis skills, and for instituting service provider performance improvement systems. Other USAID projects will provide other TA and training inputs – e.g. the HPC project will strengthen inter-personal communication. All of these inputs would be used to build the capacity of LGU policymakers and health sector staffs to finance, provide and manage quality public health services.

For Component 2, technical assistance will be provided to work with national-level policymakers and program implementers to identify and modify policies, regulations, and program implementation guidelines that hinder the sustainable provision of quality health services at the LGU level.

Potential grants to NGOs. The HSD Project will examine the feasibility of providing small grants to NGOs for use in their advocacy activities. Such grants could be used by NGOs to facilitate their participation in policy or advocacy activities – e.g. for travel to the provincial capital to take part in a meeting they could not otherwise attend, for preparation and copying of materials for presentation to the Sanggunian Bayan health committee stating their position on various budget issues, etc. Such grants could also be used for advocacy activities directed at making the community, particularly its poorest citizens, aware of the health services and financial assistance for health that are available to them – e.g. the benefits of delivering babies at a facility with a trained provider and the financial coverage provided by PHIC for such deliveries, or the importance of going to the health unit when one has symptoms of TB and the PHIC financial coverage that is available for TB care.

Such grants are expected to be small, less than $1,000, with easy-to-prepare grant requests and minimal reporting requirements (one page or less) commensurate with the size of the grant. If grants are to be provided, the grant policies and procedures will be worked out with approval by the Contracting Officer.

2. USAID/Washington

Specialized and complementary technical assistance may be drawn from the large array of existing cooperating agencies within the USAID/Washington Bureau for Global Health.

B. Implementing Partners and Schedule

1. Technical Assistance Contractors/Grantees

USAID will contract with one or more US or local firms, or a consortium of such firms, through open competition for Component 1 of the HSD Project and award a local policy consultancy institution for Component 2 of the Project. The contractors/grantees will report to the USAID Cognizant Technical Officer for administrative and technical direction. They will work directly and coordinate with DOH and other government counterparts (local and national), involved NGOs, Leagues of local government leaders, training institutions, local communities and others as appropriate. The contractors/grantees will prepare annual work plans, monthly or quarterly progress reports and annual assessments of overall implementation performance. To facilitate the delivery of technical assistance support, the contractors/grantees will be expected to set up liaison offices in Metro Manila and an appropriate network of regional offices to cover the HSD Project's target provinces and LGUs.

2. Sub-grantees and Sub-contractors

It is expected that the HSD Project will need to use national and local partners to leverage its efforts with individual LGUs. While the HSD Project will itself forge the initial working relationship with LGUs through active coaching, local partners will be needed subsequently to maintain and deepen these relationships and assist in delivering TA. National partners will be selected to provide specific expertise in areas covered by the HSD Project and will then work with LGUs directly or through the local partners. CHDs, provincial health offices, local universities, NGOs, PVOs, Leagues of local government leaders, and other organizations or firms working in areas relevant to the HSD Project will be considered for these roles. To facilitate development of this partnership network, the USAID Mission Director's approval for the HSD Project to award grants to NGOs and/or PVOs will be obtained as necessary. Direct grants to LGUs may be considered provided that authority from the Mission Director is obtained. If needed, the HSD Project will be authorized to enter into sub-contracts covering specific tasks, on the condition that any subcontractor is required to report administratively at regular intervals to the prime contractor.

3. Host Government

The DOH will be the main national government counterpart for the HSD Project, with primary responsibility for providing technical and planning guidance, and the Project will build strong institutional linkages to the DOH. The DOH, its National Health Planning Committee, NEDA, PopCom and PHIC will all play important management roles in advising, overseeing and monitoring the Project and its activities. Regional DOH offices will also be involved in supporting implementation through the CHDs.

4. LGUs

LGUs – especially cities and municipalities – are the primary target beneficiary of the HSD Project and will play a major role in its implementation. Local chief executives and LGU management staff have major roles in setting program priorities for health and family planning. At the local level, the HSD Project will work with a wide range of LGU stakeholders which may include, in addition to the mayor and vice-mayor, the municipal/city health officer, public health nurse, rural health midwife, city administrator, Sanggunian Bayan health committee chairman, municipal/city planning and development officer, RHU staff, barangay captain, and the barangay health workers.

Provinces are also LGUs and will therefore be target beneficiaries of the HSD Project. In addition, given their status vis-à-vis city and municipal governments, provincial governments can act as a replication agent for HSD Project activities. They are already a resource for the provision of training and technical assistance to cities and municipalities, alongside the CHDs which have a similar role. The provincial governments are also key players in the development of the local health systems (or district health systems) and formation of ILHZs.

5. Community and Professional Organizations

Local community organizations and groups – e.g. people's organizations, indigenous people's groups, local NGOs and PVOs, and other local stakeholders including family planning acceptors – will be important implementation partners of the HSD Project, particularly in its advocacy work at the LGU level. Likewise, the various Leagues of local government leaders (provincial governors, city and municipal mayors) and other professional organizations (e.g. of general practiioners, Ob/Gyn specialists, pulmonologists) can also be expected to play a role in advocacy. Other partners, including potential private sector partners, may be identified during implementation. The HSD Project will build linkages with many of these at the local level and some may become sub-grantees or sub-contractors.

6. Implementation Schedule

Implementation of the HSD Project is scheduled to begin on or about 1 October 2006. The HSD Project will have a five-year life, with an option to extend a further three years; this will ensure that the Project remains synchronized with USAID's current and likely future country strategy timeframes.

For Component 1, there will be three interlocking sets of tasks on the critical path at the outset: converting the illustrative geographical scope for the HSD Project into a firm scope, based on provincial governors' and city/municipal mayors' commitments; fleshing out the technical content of the contract's scope of work; getting Contractor staff, premises and infrastructure in place. TheContractor will need to submit a mobilization plan for its first 3 months within 2 weeks of authorization to proceed from USAID; thereafter, a workplan for the remaining 9 months of its first year should be developed and agreed with USAID by the end of the first calendar quarter. It is expected that the Contractor will complete the 3 sets of tasks described above sometime between the third and sixth months, ensuring that at least 6 months of technical assistance to LGUs is achieved, and can be reported on, in the first year.

For Component 2, the Grantee will submit its mobilization plan for the first three months within two weeks of authorization to proceed from USAID; thereafter, a first year annual workplan should be developed and approved by USAID within the first calendar quarter.

V. Monitoring, Evaluation and Audit Plans

This section updates the MEA section of the original DAAD. A major shift is in the acquisition and assistance plan where two awards, a contract and a cooperative agreement are contemplated.

1. Internal Monitoring and Evaluation (M&E)

Impact indicators to which the Project, and all of the other projects in the USAID health program, will contribute are at the Strategic Objective level and may include such measures as:

- Contraceptive prevalence rate.
- TB case detection rate.
- Maternal mortality ratio.
- EPI coverage rate.

USAID will take responsibility for collecting or estimating data annually on such impact indicators from national surveys or DOH statistics. The Project's approach to M&E is expected to include four elements:

- A five-year M&E plan which identifies outcome indicators to be tracked over the Project's life, and the frequency and methodology of tracking both outcome and output indicators.
- A baseline survey of the outcome indicators at the start of the Project.
- Inclusion of output indicators in each of the Project's annual work plans; these indicators may change from year to year.
- An endline survey of the outcome indicators.

The Contractor and Grantee will need to propose outcome indicators for inclusion in the M&E plan and these can be refined in discussion with USAID after the Project starts. Such illustrative indicators might include:

- Percentage of poor clients becoming new acceptors of modern FP methods.
- Percentage of surveyed health facilities with stock-outs of one or more essential drugs.
- Percentage of assisted LGUs with an increasing health share of total budget.
- Percentage of surveyed health facilities producing their own analyses of performance data.
- Percentage of surveyed health facilities receiving all four quarterly supervisory visits in a year.
- Percentage of surveyed LGUs buying contraceptives for free distribution.
- Percentage of surveyed health staff who have received FP, MCH or TB training in the last year.
- Number of LGU policy change champions created at the national level.

Many of these indicators will need to be province-specific. Performance data will be obtained from a range of sources. Output indicators can largely be tracked from LGU service statistics, annual national surveys like the Family Planning Survey and internal Project documents. Outcome indicators may be capable of tracking using the same resources but are more likely to rely on rapid surveys conducted between the baseline and endline periods. The Project will be expected to propose approaches for this, including such methodologies as Lot Quality Assurance Sampling, to keep the M&E effort reasonable in terms of both time and cost.

2. External Evaluations and Audits

The Project will be externally evaluated by the end of its third year, to provide input on any changes of programmatic focus in the last two years and provide an early indication of whether an extension will be justified. The Project will commission its own annual financial audits; USAID will arrange for any additional financial or technical audits of the Project as may be necessary.

E. Acquisition and Assistance Plan

Consistent with the acquisition plan in the original DAAD, a three-year contract was awarded to a U.S. private firm for the implementation of the former LEAD for Health Project, the predecessor of the HSD Project. This contract is expiring in September 2006 To implement the succeeding activities under the now renamed HSD Project, USAID is planning for two separate awards, reflecting the different skill sets required for national policy work compared with the LGU-specific parts of HSDP's scope.

As the primary acquisition instrument USAID/Philippines expects to solicit, negotiate and award a five-year cost-reimbursement contract, with possible extensions, to a US-based private firm or consortium of US and local firms through open competition for the LGU Systems Strengthening Component. A contract is the most appropriate procurement mechanism for this award, as USAID will need to provide a substantial amount of direction to the awardee. USAID expects the activities under this award to be undertaken in close collaboration with the DOH and with other donors who will provide assistance in the *Four*mula *One* provinces, and thus will be closely involved with the contractor in selecting provinces in which HSDP will work and in overseeing the plans that are developed with other donors. USAID Mission Director approval to award grants to NGOs and/or PVOs under the contract will be obtained.

A separate assistance instrument will be used to cover HSDP's activities under Component 2, the National Policy Support award. USAID/Philippines expects to solicit, negotiate and award a five-year cooperative agreement, with possible extensions, to a local institution to provide technical assistance for these activities. At the national level, it is critical that the assistance be provided by people who know and can interact easily with national policymakers and who are intimately familiar with the national policy scene, including the background and details of current policies, rules and regulations. A number of local institutions have already built good trust and respect among stakeholders for their work in this field and, thus, a cooperative agreement with a local Philippine institution that can provide such assistance is the most appropriate procurement vehicle.

The Request for Proposals and Request for Assistance are expected to be issued on or before 31 March 2006, for award by 30 September 2006. Additional contracts or grants to implement certain components of the project (e.g. advocacy or promotion) may also be necessary throughout the life of the project. USAID may also use any centrally-issued health IQCs, as appropriate.

USAID/Philippines also anticipates awarding separate contracts to local or U.S. firms to perform evaluations, assessments, and audits. Funding for project management, including costs associated with USAID FSN salaries, will be provided by USAID through separate contracts.

F. Financial Estimates

1. Financial Flows

The HSD Project will leverage its own staff and capabilities by working in partnership with replication agents at both the local and national levels. The Project will need to decide in consultation with USAID how best to organize financial flows between itself, these replication agents and its LGU clients. There are at least 3-4 alternatives:

- Fund the agents directly (either through grants or work orders) and have them supply services to LGUs for free. This approach is simple but not sustainable if the LGUs do not become accustomed to valuing and paying for the assistance they receive.
- Fund the agents directly and also fund the LGUs (through grants) and have the LGUs buy services from the agents. This establishes a more sustainable relationship but still does not require LGUs to commit to a value for the services by paying from their own funds.
- Fund the agents and fund the LGUs but require a counterpart or matching contribution from the LGUs for the services they receive from the Project's agents. This begins to establish a much more sustainable relationship.
- Fund the agents and have the LGUs fund their purchases of services from the agents. This is the most sustainable option since it allows the possibility of the relationship continuing well after USAID's HSD Project ends.

The choice between these alternatives depends in part on the LGUs' willingness to fund the purchase of technical assistance at this stage in their development. Some are already paying for technical training from their own funds, although the great majority still depend on almost free service from CHDs and provincial health authorities. Few are paying yet for other forms of technical assistance. The choice also depends in part on USAID's willingness to continue funding technical assistance to strengthen LGUs in the long-term, since decentralization occurred almost 15 years ago and will be almost two decades old by the end of the HSD Project.

The funding flow mechanism affects the financial estimates for the HSD Project through its impact on the size of sub-grant and sub-contract amounts. These are greatest under the first two options above but diminish under the last two options. The financial estimates below assume that one of the first two options is selected, at least at the outset. If subsequent fund availability shrinks and the LGU market is receptive, then the Project can be progressively moved towards a lower cost option under which costs are shared with LGUs.

2. Cost Estimates Funds Sourcing

The amount of the new award for the HSD Project as a whole will be $37.5 million for the period FY2007-2011. This is within the funding level of $100 million authorized in the original DAAD. Splitting HSDP into two procurements means that the contract amount for the LGU Systems Strengthening award will be $30 million, while the cooperative agreement amount for the Strengthening Health Sector Policy Formulation Systems award will be $7.5 million, including support for policy change in ARMM. HSDP activities can be funded from a variety of foreign assistance accounts:

- Child Survival and Health Programs Fund (CSH).
- Economic Support Fund (ESF).
- Development Assistance (DA).
- Other USG Agency funds.

G. Initial Environment Examination (IEE)

On February 13, 2006, the Bureau Environmental Officer of the Asia and Near East Bureau, USAID/Washington approved a blanket IEE with conditions for SO3 activities. Specific conditions include the preparation and implementation of annual training and reporting for health service providers to ensure proper healthcare waste handling and disposal.

H. Pre-Obligation Requirements

Pre-obligation requirements for each obligation to be made for HSDP will be met at the time of MAARD clearance and approval in the case of direct obligations under the MOU, or at the time of SOAg clearance and approval in the case of a SOAg with the GRP. They will be documented in ADS checklist form or action memo prepared by OPHN with PRM and RLA clearance.